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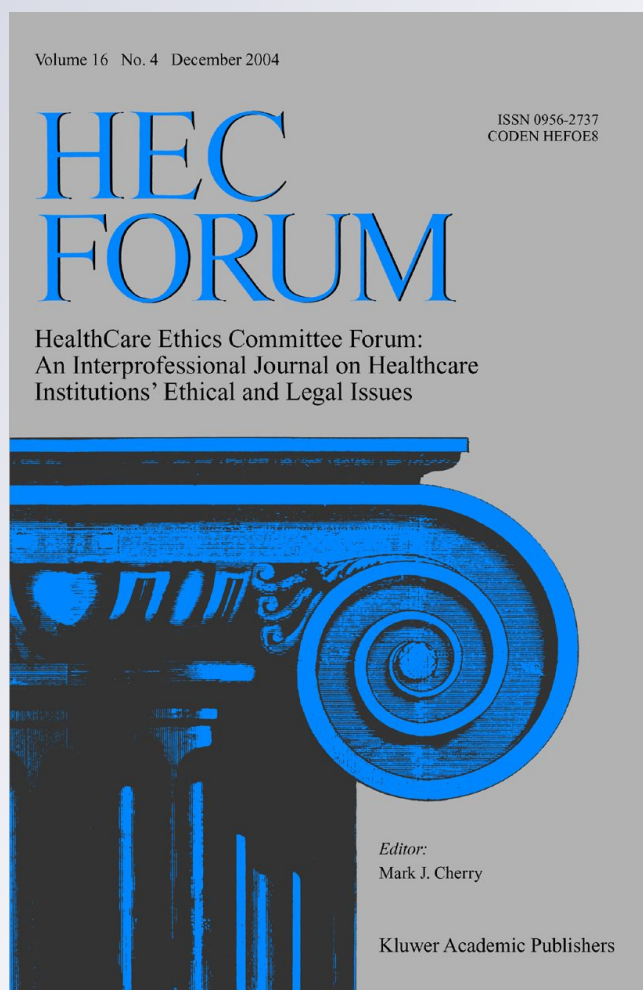
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## The Role of Family of Origin in Physicians Referred to a CME Course

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**Abstract** Few studies exist which look at psychological factors associated with physician sexual misconduct. In this study, we explore family dysfunction as a possible risk factor associated with physician sexual misconduct. Six hundred thirteen physicians referred to a continuing medical education (CME) course for sexual misconduct were administered the FACES-II survey, a validated and reliable measure of family dynamics. The survey was part of a self-learning activity. We collected data from February 2000 to February 2009. Participants were predominantly white, middle-aged males who represented the full range of medical specialties. Their results were compared against a sample of 177 physicians. The FACES-II is a self-report test that measures family of origin (the family in which one was raised) dynamics on two dimensions (1) flexibility, ranging from too flexible (chaotic) to not flexible enough (rigid) and (2) cohesion ranging from too close (enmeshed) to not close enough (disengaged). The most common family

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pattern observed among physicians accused of sexual misconduct was rigid flexibility paired with disengaged cohesion, indicative of unhealthy family functioning. This pattern was significantly different than the pattern observed in the comparison group. Physicians who engage in sexual misconduct are more likely to have family of origin dysfunction. Ethics is developmental and learned in one's family of origin. Family of origin dynamics may be one risk factor predisposing one to ethical violations. These findings have important implications for screening, education, and treatment across the medical education continuum.

**Keywords** Sexual misconduct · Boundary violations · Professionalism · Continuing medical education

## Introduction

The ethics committees of institutions and national professional organizations have long recognized sexual misconduct by health care professionals in the form of sexual relations with patients as an ethical violation and an activity suitable for assessment (Gutheil and Gabbard 1993). On their website, the International Association of Medical Colleges Ethics Committee notes that medical practice is by definition a “vocation whose core element is work based upon the mastery of a complex body of knowledge and skills and whose members profess a commitment to competence, integrity, morality, altruism and the promotion of the public good within their domain” International Association of Medical Colleges and Ethics Committee (IAOMC) ([www.iaomc.org/ec.htm](http://www.iaomc.org/ec.htm)). Medical oaths (e.g., Hippocratic Oath, Code of Maimonides, Physician's Oath, and Declaration of Geneva) and codes of medical ethics make clear that the physician's primary responsibility is to the patient. The American Medical Association (AMA) Code of Medical Ethics first adopted in 1957 and revised in 1980 and 2001 espouses nine principles of medical ethics (AMA 2002). These include upholding the standards of professionalism, respecting the law, respecting the rights of patients, and while caring for a patient, recognizing one's responsibility to the patient as paramount. In 1991, the American Medical Association's Council on Ethical and Judicial Affairs developed a report, “Sexual Misconduct in the Practice of Medicine,” that condemned sexual relations between physicians and current patients (JAMA 1991). In 2006, they noted, “Sexual contact that occurs concurrent with the physician–patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician–patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well-being” (Federation of State Medical Boards 2006). Sexual or romantic relationships with former patients are also deemed unethical if the physician used or exploited trust, knowledge, emotions or influence derived from the previous patient–physician relationship. The AMA also raised concerns regarding relationships between medical supervisors and trainees because of the inherent inequalities in status and power. Even when consensual, the AMA's position is that they are not

acceptable. Thus, sexual misconduct represents a violation of professional ethics as a fiduciary breach, abuse of a power asymmetry, exploitation of vulnerability and use of undue influence (Gutheil and Gabbard 1993).

Despite these prohibitions, sexual misconduct still occurs. The key attribute of sexual misconduct is that the behavior exploits the physician-patient or supervisor-trainee relationship in a sexual way. Boards of nursing as well as medical boards distinguish between two types of sexual misconduct: sexual improprieties and sexual violations. Sexual improprieties involve behaviors, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient. Sexual violations include physical sexual contact between a physician and patient, whether or not initiated by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual. Sexual misconduct can also be conceptualized within the framework of poor boundaries. Distinctions have been made between boundary violations and boundary crossings (Norris et al. 2003), “A boundary is the edge of appropriate professional behavior, a structure influenced by therapeutic ideology, contract, consent, and, most of all, context”. Boundary violations differ from boundary crossings. Boundary crossings are deviations from traditional clinical practice, behavior, or demeanor in which neither harm nor exploitation is involved. Boundary violations, in contrast, are typically harmful and usually exploit the patient’s needs.

The prevalence of sexual misconduct by physicians is not known but is estimated to be between 3 and 10% of practicing physicians (Swiggart et al. 2002). While only a small percentage of board disciplinary actions are for sexual misconduct, 38 to 52 percent of health care professionals report knowledge of colleagues who have been sexually involved with patients (Halter et al. 2007). Most concerning are the damaging effects of such behavior on patients and their families. The Council for Health Care Regulatory Excellence (CHRE) Report (2008) reports that psychiatric conditions including depression, post-traumatic stress disorder, and substance misuse as well as failure to access health services when needed, relationship problems, disruption to employment and earnings can all result from sexual misconduct by a health care provider to a patient/client. Additionally, the behavior can negatively impact the healthcare professional’s colleagues, family, and staff, as well as the profession at large (Gabbard 2002; Gartrell and Milliken 1992).

Sexual misconduct can arise from a variety of factors. Anecdotal data suggests many potential causes of such behaviors including a lack of knowledge about the rules governing the doctor/patient relationship, ignoring cultural norms, inadequate training, addictive disorders, psychiatric disorders, past sexual trauma, and failure to recognize non-sexual boundary crossings and dual relationships (Gabbard and Myers 2008; Irons and Schneider 1999; Spickard et al. 2008).

Family of origin issues may also contribute to physician sexual misconduct. The most well-known data comes from Valliant et al.’s (1972) original study of young physicians entering medicine. He found that physicians who chose patient care as their predominant responsibility often had more emotionally impoverished childhoods compared to non-physicians in a comparison cohort. While there have been no empirical studies that have looked at family of origin issues in physicians identified with unprofessional behavior, psychodynamic theorists have expanded on

Valliant's work and hypothesized that physicians who commit boundary violations may fulfill their own emotional needs from childhood through caring for and possibly exploiting their patients (Gabbard 1989). It has also been hypothesized that the impact and influence of the physicians' family background or family of origin is an important risk factor contributing to other areas of physician misconduct (Irons and Schneider 1999; Mengel 1987; Gabbard and Myers 2008; Spickard et al. 2002).

There are numerous theories of ethical and moral development with the most well-known being those of Piaget and Kohlberg (Duska 1975). Powers demonstrated that family interaction was a significant factor in moral development (Powers 1989). Specifically, she showed that parents' levels of affective support were positively related, and mothers' and families' levels of affective conflict were negatively related, to children's level of moral development. Similarly, Speicher suggested the importance of parenting behavior on moral development (Speicher 1994). Smetana, also acknowledges an influence of parenting on social and moral development (Smetana 1997). In light of the extant literature on normal moral development as well as the available literature on family of origin in physicians, we were interested in more closely exploring the relationship between family of origin and physician sexual misconduct.

The goal of the current study is to explore family of origin types as one possible risk factor associated with physician sexual misconduct. We hypothesized that physicians referred to a remedial CME course for lapses of professionalism that involved some form of sexual misconduct would come from dysfunctional families. Understanding specific risk factors that contribute to unprofessional sexual misconduct aids educators and ethics committees in prevention, early identification, development of appropriate interventions, and making informed decisions about healthcare providers who have engaged in sexual misconduct.

## Methods

The Center for Professional Health (CPH) at Vanderbilt University Medical Center developed *AMA PRA Category 1<sup>TM</sup>* CME programs for physicians who have engaged in unprofessional behavior. The CPH has provided remedial education for over 1600 physicians referred by practices, hospitals, physician health programs and licensing boards from across the United States and Canada. One such course, "Maintaining Proper Boundaries" specifically addresses sexual misconduct in physicians. The course has been previously described (Spickard et al. 2002; Spickard et al. 2008).

As part of the course, participants complete a number of self-report measures. The Family Adaptability and Cohesion Scale (FACES II, (Olson et al. 1992)) is a validated self-report measure of family functioning which measures the degree of flexibility and cohesion exhibited by the participant's family of origin (Koneski 2000). The tool has been used in over 1,200 research studies and has been widely used in clinical practice (Koneski 2000; Place et al. 2005). The FACES II was chosen because it is an easily administered, multi-dimensional tool that allows for comparison and continues to discriminate between different patterns of family functioning (Place et al. 2005). The instrument measures family functioning in two



dimensions—flexibility and cohesion. Flexibility represents “the amount of change and its leadership, role relationships and relationship rules. The specific concepts include leadership (control, and discipline), negotiation styles, role relationships and relationship rules” (Olson et al. 1992). Flexibility scores fall in one of four categories: chaotic; flexible; structured or rigid. The chaotic and rigid categories are reflective of unhealthy patterns of functioning while the flexible and structured categories are healthy patterns of functioning. Cohesion is defined as “the emotional bonding that family members have towards one another.” Scores again fall into one of four categories: enmeshed, connected, separated, or disengaged. Enmeshed and disengaged categories reflect unhealthy family dynamics, while the connected and separated categories are reflective of healthy families (Olson et al. 1992).

Score patterns on the flexibility and cohesion ratings were used to place participants in one of three family types: balanced (healthy scores in both flexibility and cohesion); midrange (one score from the healthy category plus one score from an unhealthy category); and extreme (unhealthy scores in both flexibility and cohesion). Balanced levels of cohesion and flexibility are most conducive to healthy family functioning, while unbalanced levels are associated with problematic family functioning.

Five hundred and thirty six physicians have participated in the “Maintaining Proper Boundaries” course at Vanderbilt. Of those, 455 consented to participate in the study. Also included were 158 participants who completed the course at a private treatment center and consented to participate in the study for a total of 613 physicians. The majority of physicians were referred from licensing boards and physician health programs, with a smaller number coming directly from hospitals, practice groups or self-referral.

Most physicians were mandated to attend the CME course because of an allegation or conviction of sexual misconduct. The misconduct ranged from inappropriate comments, jokes, or an affair with staff and/or colleagues to a sexual violation or impropriety involving patients.

A comparison group was recruited by mass e-mail solicitation provided by SK&A from their physician e-mail listings. Prospective participants ( $N = 6441$ ) from Tennessee, Arkansas, North Carolina and Massachusetts were invited to participate in an anonymous survey. Participants were asked to complete a demographic questionnaire and the FACES-II instrument. To allow for maximum confidentiality, participants consented, submitted and completed the survey via SurveyMonkey<sup>®</sup>, so there was no link between personal identifying information and the information they provided. The number of total surveys completed was 177, representing a 3% response rate, which is not unusual for a random mailing to individuals with whom there is no previous relationship. In light of the response rate, we were interested in ascertaining whether the respondents were representative of physicians at large. Thus we compared our comparison group to demographics from the AMA Census of Physicians in the United States (AMA 2010). No significant differences were noted leading us to conclude our sample was representative of practicing physicians in the United States in terms of ethnic composition as well as specialty and practice types.

The Institutional Review Board (IRB) at Vanderbilt University Medical Center oversaw the study.

## Results

The data from the two locations were compared on demographic characteristics including age, gender, ethnicity, type of practice and specialty. No differences were found so the data were pooled in all subsequent analyses. Table 1 presents demographic data including age, gender, and specialty of participants. Physicians referred for sexual misconduct were predominantly male, white, married, middle-aged, from solo or group practices (versus hospital practices) and represented a variety of medical subspecialties. The comparison group included more female physicians ( $p < 0.0001$ ), more medical ( $p < 0.0001$ ) and surgical ( $p < 0.01$ ) specialties, fewer generalists ( $p < 0.0001$ ), fewer divorced physicians ( $p < 0.0001$ ) and more physicians who indicated an academic/university practice ( $p < 0.0001$ ). The sexual misconduct group had more ethnic diversity represented than the comparison group. There were no other statistically significant differences between the groups.

The physicians' responses to the FACES (Table 2) in both the educational remediation group and the comparison sample were classified into one of three possible categories: normal as to flexibility and cohesion, mid-range which is normal in either flexibility or cohesion and extreme on the other dimension, and extreme in both dimensions. The relationship between these characteristics and membership in either the remediation or comparison sample was examined employing a logistic regression analysis with the categorical independent variable family dynamics. The relationship was found to be significant overall ( $p < 0.001$ ) for family dynamics. For the individual categories, both mid-range and extreme categories were significantly more likely to be associated with the remediation condition than the balanced category ( $p < 0.001$ ; odds ratios of 3.49 for the extreme category and 2.62 for the mid-range category.)

The distribution of scores of 613 of physician participants is provided in Table 2. About 32% of the attendees described having been raised in families that were "balanced", while 30% fell into the "midrange" group. The largest percentage, (38%) had family patterns that fell into the "extreme" or most unhealthy family structure group. Of particular interest is that 91% of the physician families that were scored in the "extreme" category fell into the disengaged and rigid group. The number of physicians in the disengaged and rigid group represents the largest subset of the physicians accused of sexual misconduct (35% of total cohort) completing the FACES II questionnaire. There were significantly more physicians in this pattern than the 15 other patterns ( $p < 0.05$ ), even after adjusting for multiple comparisons. When looking at whether a physician had either rigid flexibility, disengaged cohesion or both, a majority (58%) of the sexual misconduct group fell into these categories.

Since the comparison group differed significantly from the sexual misconduct group in terms of racial composition and specialty type, a linear regression model was used to determine if family dynamics might be associated with demographic variables. There were no significant relationships found between race, gender or specialty type and family dynamics in the comparison group.



**Table 1** Remediation and comparison

	Remediation ( <i>n</i> = 613)	Comparison ( <i>n</i> = 177)
Mean age	50 (31–80)	N/A
Male/Female %	94% vs. 6%	67% vs. 33%
Race		
White*	80%	88%
Black**	4%	1%
Hispanic**	5%	1%
Asian*	8%	2%
Other	2%	1%
Unknown	1%	7%
Marital status		
Single	6%	3%
Married*	63%	85%
Divorced*	25%	3%
Widowed	0%	1%
Separated	1%	1%
Unknown	3%	7%
Specialty		
Anesthesia	4%	4%
Generalist (Med, Peds, FP)**	37%	24%
Medicine specialty**	5%	21%
General surgery*	3%	2%
Surgical specialty	8%	16%
Emergency	3%	1%
Ob/Gyn	7%	4%
Psychiatry	10%	6%
Neurology**	2%	0%
Other**	17%	14%
Unknown	2%	7%
Practice		
Solo**	80%	48%
Partner/Group		
Walk-in clinic		
Hospital-based	15%	13%
Academic/ University**	N/A	29%
Other <sup>a</sup>	1%	3%
Unknown	3%	7%

<sup>a</sup> DO, radiologist, chiropractor, pathologists, ophthalmologists, podiatrists and physician assistants

\*  $p < 0.01$ , \*\*  $p < 0.0001$

## Discussion

This exploratory study examined family dynamics in a group of physicians referred because of concerns about sexual misconduct to a remedial continuing medical

**Table 2** Family types of physicians participating in the CME sexual boundaries course (Remediation group) and a comparison sample

	Remediation ( <i>n</i> = 613)	Comparison ( <i>n</i> = 177)
Balanced	194 (32%)	88 (50%)
Separated Structured	38	12
Separated Flexible	20	7
Connected Structured	47	21
Connected Flexible	89	48
Midrange	181 (30%)*	60 (34%)
Disengaged Structured	33	3
Disengaged Flexible	6	2
Separated Rigid	65	13
Separated Chaotic	2	1
Connected Rigid	29	9
Connected Chaotic	10	8
Enmeshed Structured	11	0
Enmeshed Flexible	25	24
Extreme*	238 (38%)*	29 (16%)
Disengaged Rigid	217 (35%)	18 (10%)
Enmeshed Rigid	5	0
Enmeshed Chaotic	15	0
Disengaged Chaotic	1	11
Any Rigid/Disengaged	356 (58%)	56 (32%)

\*  $p < 0.01$ 

education course. To our knowledge, our sample of referred physicians is the largest cohort of physicians accused of sexual misconduct who have attended a remedial education course and have been systematically studied. Our sample is predominantly white males and represents a full range of medical specialties and practice types. Unlike previous studies, (Dehlendorf and Wolfe 1998) specialties such as psychiatry and ob/gyn which are traditionally thought to be more prone to be at risk for sexual misconduct were not over-represented. It should be noted that our sample is not a random sample, nor a sample that was derived from disciplinary data, but rather reflects referrals to a remedial CME program.

There has been little empirical research on the psychological profiles of this group of physicians particularly as it relates to family dynamics. Dorr (1981) noted that the literature on problematic physicians is “rich in clinical observations, but lacking in quantitative data.” Nearly 30 years later, the paucity of empirical studies comparing doctors in difficulty to a normal comparison group of physicians persists. In 1994, Irons and Schneider reported on 137 consecutive healthcare professionals referred for a formal multidisciplinary assessment as a result of alleged professional sexual offense. In addition to describing work place difficulties, they presented data on diagnostic formulations of the referred group and found a number had significant clinical diagnoses. One study evaluating personality profiles of doctors referred for different types of professional difficulties found that 25 physicians referred for sexual boundary violations generated the fewest normal profiles on the Minnesota

Multiphasic Personality Inventory-2 (MMPI-2) and Personality Assessment Inventory (PAI). They found that as a group, boundary violating physicians tend to experience greater problems with impulse regulation, are more self-centered, less empathetic, less likely to take responsibility for their offences (more likely to blame others or circumstances), and less likely to be influenced by societal norms in comparison to the two other groups of physicians referred for other types of problematic behavior. The physicians with boundary issues also produced the most MMPI-2 protocols suggesting exaggerated attempts to present themselves in an unrealistically positive light (Roback et al. 2007). Neither of these studies presented a normal comparison group nor did they formally assess family dynamics.

The results of the FACES II suggest a high prevalence of family dysfunction in our sample of physicians referred for sexual misconduct. Most striking is that these physicians have a significant grouping with rigid and disengaged (unhealthy) patterns of family functioning.

Mengel (1987) theorized that past family of origin relationships and experiences gives each of us a template with which we organize and view the world. Furthermore, Gabbard (1989) also described how untreated psychological problems from childhood may foster unprofessional relationships in therapists working with psychotherapy patients. The finding from our study that physicians referred as a result of sexual boundary concerns report rigid and disengaged families may offer credence to this theory.

Much effort both in terms of time and financial resources are invested in training physicians. We recognize that sexual boundary violations are destructive to the patient, the physician and the community at large and such behavior cannot be tolerated. Clearly, it is in the best interest of all if medical students, residents, physicians and other health care providers can be appropriately identified prior to the occurrence of inappropriate sexual behavior. Failing that, it would be important to determine if those who have behaved inappropriately can be remediated. There are many factors that have been hypothesized to contribute to sexual boundary violations. These include lack of knowledge around what are appropriate boundaries, lack of skills in establishing and maintaining appropriate boundaries, external stressors, personality characteristics and clinical conditions such as addictive disorders and affective disorders. Our findings suggest that unhealthy patterns of family functioning in one's family of origin may also be a risk factor for sexual misconduct.

Ethics committees may want to consider these findings in the context of both proactive educational training and in the consideration of determination of consequences following a boundary violation. Thus, in constructing educational programming it may be of benefit to include ethical and professional codes, knowledge about appropriate boundaries, skills training to assist in establishing and maintaining them, as well as discussion of factors that increase vulnerability of engaging in sexual misconduct. In addition to proactive educational programming, consideration of all the factors that have contributed to the behavior may assist in the deliberation process and provide guidance and insights regarding whether the appropriate course of action is to recommend further evaluation, educational remediation, treatment or dismissal.

## Limitations

Given that the FACES II is a self-report measure, it is susceptible to biases in responding, especially for retrospective ratings such as were obtained in this study. Thus, the results cannot be assumed to be a veridical characterization of respondents' families, despite probably validly reflecting the respondents' current view of their families-of-origin. In addition, there were differences between the remediation group versus the comparison group in terms of gender, race and specialty type. This is not surprising given that there are a number of studies that suggest that broadly speaking these variables are risk factors for professional difficulties (Kohatsu et al. 2004, Elkin et al. 2011). Also there was no evidence that these variables were related to family dynamics, however the difference in the distribution of these characteristics between our referred and the normal comparison group warrants further study as it is possible that gender might in some way interact. This initial study focused on all the participants without regard to the type of boundary infraction which ranged from inappropriate comments to a sexual relationship with a patient. Another limitation is the small sample size and small response rate of our comparison sample. While low response rates to mass surveys are common, there remain questions about selection bias as well as generalizability of the results.

## Conclusion

The FACES II data from 613 physicians referred for sexual boundary violations offers an objective measure of family flexibility and cohesion that provides preliminary support for the hypothesis that dysfunctional patterns of family functioning may contribute to boundary violating behaviors in physicians. Such findings have guided curriculum improvement for the “Maintaining Proper Boundaries” CME course at Vanderbilt through the development of genogram exercises, role-plays, and insight-oriented activities combined with other more cognitive behavioral activities that address other risk factors previously mentioned. The Vanderbilt CME program has successfully helped many physicians return to practice medicine safely and professionally. Future research should be directed at determining if there a relationship between the severity of misconduct and family type. Further studies looking at differences in family dynamics of healthcare providers as a function of severity of the behavior as well as for those referred for different types of professional difficulties would also be of interest and would help to clarify the potential role of family dynamics. Educational strategies that address family of origin as part of educational programming about professionalism specifically in boundary issues might be useful in preventing sexual misconduct earlier in medical education training or at the very least can be used to identify physicians who might be at risk of sexual misconduct.

**Conflict of interest** None.

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